Legislative Testimony
Human Services Committee
HB 6550 AAC Medicaid Provider Audits
Wednesday, February 11, 2015
Jeffrey Berkley, DDS

Senator Moore, Representative Abercrombie and members of the Human Services Committee, my name is Jeffrey Berkley. I am an Oral and Maxillofacial Surgeon who participates with the Medicaid Program. My single specialty group practice consists of eight surgeons that practice in five offices throughout Connecticut. I am an attending in the Department of Dentistry at Yale, teaching in their residency program, and I am head of the Dental Department at Midstate Medical Center. I am also the current President of the Connecticut State Dental Association, and today I am testifying on behalf of the CSDA and its nearly 2,400 member dentists, in favor of House Bill 6550, An Act Concerning Medicaid Audits.

To start, I would like to thank the Human Services Committee for your efforts in bringing all Medicaid provider associations together in an attempt to improve the current audit process. The Connecticut State Dental Association as well as the other provider groups here today believe that the audit process is needed but must be fair and transparent. To date, very little progress has been made on the part of the Department of Social Services to ensure fairness and transparency in this process. The Medicaid Provider Coalition has developed a document outlining the elements we feel can accomplish this, which is attached to my written testimony.

As President of the CSDA, I have heard from numerous members who have experienced a Medicaid audit through the Department of Social Services. To a person, I have heard stories of administrative personnel-- not medically trained individuals -- determining medical necessity; unreasonable and non-random sampling of charts to be included in the audit; and at the end of the process, seemingly small numbers of clinical errors being extrapolated to hundreds of thousands of dollars in alleged overpayments. I personally happened to be involved in one of the earliest audits and can say that the stories I've heard from countless CSDA members reflect the same experience that I myself had with the process.

It appears that the majority of findings involve disputes over coding definitions, appropriate but uncovered clinical treatments, guidelines for documentation that have not yet been published by the DSS, and, in the case of dental Medicaid audits, standards being enforced that do not correspond to current dental standards set forth by the American Dental Association or other national dental specialty organizations. I am hopeful that we can address many of these issues for dentists and many other provider groups if the DSS was compelled to collaborate to improve the audit process fairness through this legislation.

The remainder of my comments will focus on two specific areas noted within the "Summary of Proposed Changes to the DSS Provider Audit Process" document prepared by the Medicaid Provider Coalition, which I have attached to my written testimony. In particular, the issues of **extrapolation** and **sampling methodology.**

The law which allows extrapolation to audit violations does not require extrapolation for all findings. It was intended to fight fraud. The instances I noted previously certainly do not qualify as fraud. Yet the auditors are extrapolating all negative findings to the entire universe of patients within the audit period, triggering repayment demands that are extreme for even minor issues. The guiding statute and regulations should provide that extrapolation not be conducted across disparate services; extrapolation should only apply to "like claims". Furthermore, extrapolation should not be applied to circumstances involving clerical errors. This is especially relevant when evidence supports that the services subject to the claim were performed as agreed to, and there was no financial impact resulting from the error. It is this inappropriate extrapolation, compounded by the fact that there is no consistent definition of "clerical errors" that creates the most concern.

Finally, valid extrapolation projections require that the audit be conducted on a statistically valid and random sample of records. First and foremost, the sampling methodology should be disclosed to the provider at the outset of the audit. This is currently not the case with dental Medicaid audits.

The CSDA and its member dentists are proud to know that our state has risen from one of the worst performing dental Medicaid programs in the country, to become a national model for providing access to care for the citizens of Connecticut. With the amount of negative feedback being created by the audit process and extrapolation I fear that we will potentially be faced with the loss of many of our very best providers. The CSDA spent great effort to recruit these providers into the Husky program. These highly proficient and honest dentists who have now welcomed Husky patients into their practices are being dissuaded from continuing to do so by the loss of fairness, reduced administrative burden, and transparency of the program that we promised them. Let me be clear: the CSDA recognizes that an audit process is necessary. We have absolutely no tolerance for fraud, and those practitioners who have been found to be willfully defrauding the State should be prosecuted to the fullest extent of the law.

We appreciate the intent of HB 6550, and hope that these comments and suggestions, along with those of our Medicaid provider colleagues from other medical disciplines will help to codify an audit process that will establish a fair and transparent understanding and expectations from the perspective of the providers, and the Department of Social Services. Again, I reiterate our desire to be a part of this process, and I thank you for your time this evening.

Respectfully Submitted,

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Summary of Proposed Changes
Department of Social Services Provider Audit Process

A coalition of care providers met in 2014 to identify key measures necessary to achieve transparency in audit practices, clarity for Medicaid providers, and fairness of the audit process. The coalition includes the Connecticut Hospital Association, the Connecticut Association for Healthcare at Home, the Connecticut Association for Health Care Facilities, the Connecticut State Medical Society, LeadingAge Connecticut, the Connecticut State Dental Association, the Connecticut Community Providers Association, the Connecticut Pharmacist Association, the CT Homemaker & Companion Association, Companions and Homemakers, CVS Health, Quest Diagnostics, the Northeast Pharmacy Service Corp., and the Connecticut Association of Community Pharmacies, Inc. The coalition's recommendations are described below.

Extrapolation

Extrapolation is a statistical technique for inferring what occurred outside the range of what was actually measured, and should not be used in the following circumstances:

1. **Across Disparate Services:** Do not extrapolate across disparate services, apply only to like claims.
2. **ED vs. Non-ED Claims:** Claims related to emergency medical care should not be extrapolated to claims not related to emergency care.
3. **Observation Care:** Claims for any appropriate medical care for anyone in observation status after 23 hours.
4. **Clerical Errors:** Circumstances involving a clerical error, especially when there was no financial impact resulting from the error.
5. **Unintentional Overlap in Services**: When two unrelated providers submit claims for serving Medicaid clients during the same time period, caused by circumstances beyond their control.
6. **Transition to New Billing Procedures**: When payment or billing errors result from a transition to a new billing procedure.
7. **Prior to Policy Effective Date**: When claims were submitted prior to the issuance of the specific audit and/or reimbursement policy that is the subject of the audit.
8. **No Notice of Service Plan Amendment**: When the provider demonstrates that it was not made aware of a plan amendment prior to providing the service.
9. **Unique or Rarely Used Claims**: Unique claims should be dealt with individually.
10. **Outlier Claims**: Outlier claims should be dealt with individually.

Sampling Methodology

Extrapolation projections must be based on a statistically valid random sample, as reviewed by a statistician or by a person with equivalent expertise in probability sampling and estimation methods.

1. **Early Disclosure of Sampling Methodology**: The methodology should be disclosed at the outset of the audit.
2. **Sample Stratification**: Claims should only be pulled that are specific to the procedure or service identified by the CPT code.
3. **Use of Median vs. Average**: The median should be applied in cases in which claims with multiple services are being extrapolated to reduce the overweighting of multiple claims.
4. **Paid Claims Only**: The universe of claims to be sampled cannot exclude claims for which no payment was issued.

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Fairness of the Audit Process

These measures should be implemented to ensure the fairness of the audit process:

1. **Compliance with Federal and State Rules:** A provider should be permitted to raise, at any time, including as an item of aggrievement, that its compliance with a state or federal law or regulation explains or negates a negative finding in an audit.
2. **Additional Information to be Provided by the Auditor**: Auditors should provide the following information regarding audit activities:
    a. At the commencement of the audit:
        i. The name and contact information of the specific auditor(s);
        ii. The audit location – either on site or through record submission;
        iii. The manner by which information shall be submitted; and
        iv. The sampling methodology to be employed in the audit.
    b. When extrapolation is used, the formula and data/claims used in the sampling shall be provided to the provider and disclosed in the audit report.
3. **Auditor Qualifications:** Auditors must undergo training and possess certain qualifications:
    a. Auditors must have coding experience, including but not limited to applicable ICD, CPT, and HCPCS codes.
    b. Decisions regarding medical necessity must be made by a professional licensed in the same clinical discipline.
    c. Auditors must have general knowledge of the particular provider services under audit and the Medicaid program they are auditing.
    d. Sampling methodology must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimate methods.
4. **Composition of the Audit Team**: The team must include qualified individuals, such as medical or dental professionals experienced in treatment, billing, and coding procedures.
5. **Appeals:** The audit appeals process should include at least 2 levels: (1) the initial request for reconsideration and (2) a second level appeal to an external party.
6. **No Recoupment While Appeal is Pending:** A provider will not be subject to alleged overpayment, re-payments, or recoupment while an appeal is pending.
7. **Look-Back Period:** Expressly limit the "look-back" period for audits to claims that are not more than two years from the date the claim was filed.
8. **Timing and Frequency of Audits:** Achieve greater transparency in the scheduling and frequency of audits. The Department should complete the audit report in a timely fashion.
9. **Conference before Issuing a Preliminary Written Report**: When an extrapolated figure exceeds $200,000, a conference must be held before the auditor issues a preliminary written report.
10. **Comparison of Preliminary Audit Findings vs. Final Written Report**: Publish an annual report comparing de-identified audit findings included in preliminary written reports against those included in final audit reports.